		(X2) MI	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	a. BUILDING 00		COMPLETED	
		155512	B. WIN	G		04/26/	2012
NAME OF I	PROVIDER OR SUPPLIE	ER.			ADDRESS, CITY, STATE, ZIP CODE		
DDOVEN	IA SACRED HEAR	DT HOME			MAIN ST A, IN 46710		
	1				T		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F0000		,					
	This visit was fo	or a Recertification and	F00	00	Submission of this plan of		
	State Licensure	Survey.			correction and credible allega		
		3			of compliance does not consti		
	Survey dates: 4	/23-4/26/12			an admission by the certified a licensed provider at Provena	anu	
					Sacred Heart Home that the		
	Facility number	: 000404			allegations contained in the		
	Provider numbe				survey report are a true and accurate portrayal of the provi	iolon	
	Aim number: 1	00290810			of nursing care and services a		
	Survey team: Carol Miller RN, TC				this health care facility. Prove		
					Sacred Heart Home, as a		
					licensed and certified provider	-,	
	Honey Kuhn Ri				recognizes its obligation to provide legally and medically		
	Christine Fodre				required care and services to	our	
	Tim Long RN				residents in an economic and		
	_	, (4/23-4/25/12)			efficient fashion. Please acce	pt	
	Julie Wagoner I				this plan of correction as our written credible allegation of		
					complaince.		
	Census bed type	2:					
	SNF/NF: 103						
	SNF: 16						
	Total: 119						
	Census payor ty	pe:					
	Medicare: 9	-					
	Medicaid: 75						
	Other: 35						
	Total: 119						
	Sample: 24						
	These deficienc	ies also reflect State					
	findings cited in	accordance with 410 IAC					
	l						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
ANDILAN	OI CORRECTION	155512	A. BUILDING	00	04/26/2012
		<u> </u>	B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		MAIN ST	
PROVEN	IA SACRED HEAR	T HOME		a, IN 46710	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG	16.2.	CLSC IDENTIFFING INFORMATION)	TAG	DEFICIENCE!)	DATE
	10.2.				
	Quality review of	completed 5/1/12			
	Cathy Emswiller				

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Event ID: **W56111**

Facility ID: 000404

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	OF CORRECTION	IDENTIFICATION NUMBER: 155512	A. BUILDING 00		COMPLETED 04/26/2012		
		100012	B. WIN			0 1/20/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PROVEN	A SACRED HEART	HOME		515 N M AVILLA,	, IN 46710		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157 SS=D	resident; consult and if known, not representative or member when the the resident which the potential for rintervention; a signesident's physical status (i.e., a deteor psychosocial sthreatening cond complications); a significantly (i.e., existing form of the consequences, of treatment); or a discharge the resispecified in §483	ME/ROOM, ETC) mediately inform the with the resident's physician; ify the resident's legal an interested family ere is an accident involving h results in injury and has equiring physician gnificant change in the al, mental, or psychosocial erioration in health, mental, etatus in either life itions or clinical need to alter treatment a need to discontinue an reatment due to adverse r to commence a new form a decision to transfer or sident from the facility as .12(a). also promptly notify the					
	representative or when there is a cassignment as space a change in reside State law or regular paragraph (b)(1) The facility must update the address resident's legal refamily member.	record and periodically ss and phone number of the epresentative or interested	F01:	57	The facility will continue to		05/18/2012
	interview, the factory physician of pres	ation, record review and cility failed to inform the ssure ulcers for 2 of 5 ants reviewed for pressure the of 24.	101.	<i>,</i>	monitor and treat the pressure ulcer for resident #95 until resolved. Resident #103 pressure area has resolved on heal on 5-8-2012. The correct	his	03/10/2012

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Event ID: **W56111**

Facility ID: 000404

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		155512	B. WIN			04/26/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			MAIN ST		
PROVENA SACRED HEART HOME					, IN 46710		
					,	T gra	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
TAG	REGULATORT OR	LESC IDENTIFTING INFORMATION)		TAU	action to prevent other resider		
					from being affected by the	11.5	
	Findings include	:			deficient practice is when a		
					pressure ulcer is discovered the	ne	
	1. Resident # 95'	s clinical record was			nurse who discovered the		
	reviewed 4/23/12	2 at 11:30 A.M The			pressure ulcer will initiate the		
	record indicated	the resident was admitted			pressure ulcer assessment for	m	
		6/20/07 and had			and push tool, see		
		ling, but not limited to,			attached.When a pressure ulc is found the physician and	ei	
	~	ase, congestive heart			POA/guardian will be notified.		
	failure and renal				The pressure ulcer will be		
	lanuic and ichai	ianuic.			documented and care planned	i.	
	D : 0.1	-1 4			Treatment and wound measur	•	
		sident's nurse's notes			is done weekly on day shift. A		
		9:08 P.M. indicated			the weekly documentation and		
	"Follow up from	Podiatry clinic. Noted on			care plan update the pressure ulcer assessment form will be		
	right great toe, d	istal top, area pinkish red.			filed on the resident		
	Blister like intac	t area present. Skin rough			chart.Inservice training for stat	f I	
	to touch".				will be completed by 5-18-201		
					on the initiation process of the		
	Review of the Po	odiatry progress not from			physician notification of a new		
		d a pressure area noted			pressure area. The DON or		
	distal right great	-			designee will review charting for residents with pressure		
	i distai rigiit gicat	ioc.			sores ongoing to verify that		
	T1				physicians are notified of resid	lent	
	_	er assessment form from			pressure areas.Unit Nurse		
		d the would was 0.7			responsibleQA Nurse to monit		
	` ′	x 1.0 cm, dry scab. The			and report to QA team monthly	y	
	wound was unsta	ageable.			for additional monitoring		
	On 2/1/12 at 1:1	1 P.M. a nurse's note					
	indicated a 60 da	ny check was completed					
		and the resident's right					
		sessed with no changes.					
	An observation	on 4/24/12 at 11:40 A.M.					
	or the right great	toe indicated to top of				1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
TUNDILAU	of condition	155512	A. BUILDING B. WING 04/26/2012				
	PROVIDER OR SUPPLIE		STREET 515 N I	ADDRESS, CITY, STATE, ZIP CODE MAIN ST A, IN 46710			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	cm blackened ar surrounding wo An interview wi 10:45 A.M. indi the physician of	pproximately 0.5 cm x 0.4 rea, no drainage, tissue und pink and blanchable. At the RN #1 on 4/25/12 at cated no notification of the pressure ulcer to the pressure too was legated prior.					
	to 2/1/12.	great toe was located prior ith the Director of Nursing					
	(DN) on 4/26/12 no notification of	2 at 3:00 P.M. indicated of the physician of the othe resident's right great					
	conducted on 04 A.M 11:30 A. Manager, indica unstageable pres heel. She indica with a blister on	M., R.N. #2, the Unit ated Resident #103 had an assure ulcer on his right ated he had been admitted his right heel from an ar following surgical repair ft hip.					
	at 12:13 P.M., s the dining room The resident wa bootie on his rig visible on the he	vas observed on 04/23/12 eated in his wheelchair in /lounge on the rehab unit. s noted to have a quilted tht foot and a dressing was eel area. pressure ulcer was					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155512	A. BUII	LDING	00	COMPL 04/26/	ETED
		100012	B. WIN	_	DDDECC CITY CTATE ZID CODE	0 1/20/	20.2
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PROVEN	IA SACRED HEART	HOME	515 N MAIN ST AVILLA, IN 46710				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCI)		DATE
		4/12 at 2:45 P.M. The					
		unded, silver dollar sized					
	•	the bottom posterior					
	_	neel. The bottom portion					
		s a dried, brown colored					
		d area the top 1/3 and a					
	-	e blister was noted to be					
		ck, thick tissue. RN #2					
		uld call the black area,					
	eschar. The esch	ar area covered the entire					
	top 1/3 of the original	ginal blistered area, was					
	shaped like a but	ton mushroom cap, and					
	was thick and vis	sibly rimmed on one side					
	of the eschar area	a. The top of the					
		d toes were pink in color.					
	The clinical reco	rd for Resident #103 was					
	reviewed on 04/2	23/12 at 2:30 P.M.					
	Resident #103 wa	as admitted to the facility					
	on 04/06/12 from	an acute care facility					
	with diagnoses, in	ncluding but not limited					
		t hip fracture repair,					
	_	history of a cerebral					
		t, hypertension, and					
	constipation.) J ₁					
	- 3.1.0.1.p						
	Review of an elec	ctronic Admission					
		pleted on 04/07/12 at					
	•	N #4, indicated under					
	_	umentary" the resident's	1				
	_	s pale in color, a bruise					
		e documented. Although					
		_					
	_	to document a blister,					
	nematoma, or pre	essure ulcer, none were					

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Event ID: W56111

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	COMPLETED		
		155512	B. WIN	G		04/26/2012	
NAME OF E	DOWIDED OD SLIDDI IED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				515 N M	IAIN ST		
PROVENA SACRED HEART HOME				AVILLA	, IN 46710		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ļ
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	noted.						
		ew of nursing progress					
		l by RN #4, on 04/06/12					
	at 11:48 P.M., ar	nd RN #3 on 04/07/12 at					
	4:09 P.M., indica	ated both nurses					
	documented an a	ssessment of all of the					
	resident's system	s and body, but failed to					
	document a blist	er or impaired skin on the					
	resident's right h	eel.					
	A "skin condition	n flowsheet", completed					
		04/06/12 indicated the					
	*	matoma "ota" (open to					
	_	ed with sheepskin.					
	an) maci cicvati	ed with sheepskin.					
	Review of the ad	lmission physician's					
		06/12, indicated there					
	•	orders related to the care					
	_	of a blister on the					
		eel. The transfer					
	_						
		rom the acute care center					
		a pressure ulcer or blister					
	on the resident's	right heel.					
	A nursing and	oss nota datad 04/07/12					
		ess note, dated 04/07/12					
		dicated the following:					
	1	ent's) right heel there is a					
		neasures 4.5 x 5.4 x<.1.					
		eel was placed in sheep					
	skin protector"						
	documentation th	ne physician was notified					
	of the resident's	pressure ulcer.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
		155512	A. BUI B. WIN	LDING		04/26/	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				MAIN ST		
PROVEN	IA SACRED HEAR	ГНОМЕ		AVILLA,	, IN 46710		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		tment record for April		TAG	DIA ICILICE I)		DATE
		at #103 indicated a					
	pressure relievin						
	1 ^	04/06/12, and "Monitor					
	_	neel et (and) elevate with					
	sheep skin on wh						
	implemented on						
	protector at all ti	mes was implemented on					
	04/10/12, and ke	ep right lower extremity					
	elevated in bed/v	vheelchair was					
	implemented on	04/10/12.					
	There was no do						
		otified of the blister on					
	_	ht heel until an order for ent was received on					
	04/13/12.	cht was received on					
	04/13/12.						
	Interview with the	ne Director of Nursing, on					
		A.M., indicated Resident					
	#103 had been a	dmitted to the facility on					
	04/06/12 with the	e blister to the right heel.					
	A document obta	nined from the acute care					
	facility, indicated	d the resident had a					
		04/04/12. In addition, a					
	1 -	ne physician indicated he					
		ent at the facility on					
		s aware of the resident's					
	right heel blister.						
	The Director of 1	Nursing, on 04/25/12 at					
		ated the Admission					
		ipleted by RN #4 on					
		accurately documented					
		,					

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		DENTIFICATION NUMBER: 155512	(X2) MULTIPLE CO A. BUILDING B. WING	00	04/26	LETED 5/2012		
	PROVIDER OR SUPPLIER	НОМЕ	STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE		
	did not mention th	now why RN #3 and #4 ne presence of a pressure ess notes until 04/07/12						
	3.1-5(a)(1)							

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
ANDILAN	155512	A. BUILDING 00		- 04/26/2012	
	100012	B. WING	A DDDDEGG CHTM CTATE THE CODE	04/20/2012	
NAME OF I	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE MAIN ST		
PROVEN	IA SACRED HEART HOME		A, IN 46710		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F0221	REGULATORY OR LSC IDENTIFYING INFORMATION) 483.13(a)	TAG	DEFICIENCT)	DATE	
SS=D	RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to				
	treat the resident's medical symptoms.	E0221		05/19/2012	
	Based on interviews, observations, and	F0221	Corrective action taken; the activity care plan on resident	#62	
	record review, the facility failed to follow		was updated on 5-7-2012, the		
	the Care Plan in regard to the release of a		restraint care plan was updat		
	restraint during activities.		for resident #62 on 5-8-2012.		
	This deficiency affected 1 of 1 resident		resident having the potential affected by the deficient pract		
	reviewed for restraints in a sample of 24 (their care plans will be review		
	Resident #62).		at least quarterly or with a		
	Findings include:		significant change of condition Nursing staff will monitor residents that are on restraint daily by pursing documentations.	ts	
	The clinical record of Resident # 62 was		daily by nursing documentation linservice will be provided to s	l l	
	reviewed on 4/23/12 at 12:00 p.m. and		on care plan updates by	, can	
	indicated Resident #62's diagnoses		5-18-2012. The DON or		
	included, but were not limited to,		designee will observe resider	nts	
	Alzheimer's disease and anxiety and		with restraints to verify that restraints are implemented in		
	hallucinations.		accordance with residents' ca plans ongoing. Nurse is		
	The Physical Restraint Assessment form dated 11/29/11 indicated a padded laptop cushion to her wheelchair was recommended by Physical Therapy due to the residents safety, poor balance and frequent falls. The alternatives had already been tried for the resident were 1 on 1 supervision, activities, medications		responsibleDON to monitorQ Team will monitor monthly	A	
	for anxiety and a merry walker.				
	The Quarterly Restraint Effectiveness				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLI	ETED
		155512	B. WIN		04/26/2012		2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			MAIN ST		
PROVENA SACRED HEART HOME		T HOME			, IN 46710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		0/12 indicated the padded					
	laptop cushion h	ad not fallen and had					
	increased the res	sidents independence.					
	The Care Plan in	regard to the padded					
		ated 11/29/11 indicated					
		resident with an activity					
	-	re 'restraint free' time can					
		he Care Plan further					
		ly the lap top cushion					
		esident if the resident had					
		to allow the resident with					
	"self mobility"	and to release the					
	restraint every 2	hours for 15 minutes.					
	On 4/24/12 at 9:	15 a.m. the resident was					
		unit's dining room seated					
		with the padded laptop					
		resident's lap with					
	I -	present. The resident					
	was alert and cal	lm.					
		15 p.m. the resident was					
	observed in the u	unit's dining room seated					
	in a wheelchair v	with the padded laptop					
		the resident's lap. The					
		served to be in an activity					
	with Activity Ai						
		at probotic					
	On 1/25/12 at 2.	50 p.m. LPN # 6 was					
		•					
		egard to the residents					
	laptop cushion re						
		esterday right after the					
	resident ate brea	kfast the resident was					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED			
MIDILAN	155512	A. BUILDING	00	04/26/2012			
	100012	B. WING	ADDRESS CITY OF THE CAR CORE	3 1/20/2012			
NAME OF I	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
PROVEN	IA SACRED HEART HOME	515 N MAIN ST AVILLA, IN 46710					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG	transferred from the comfort chair to the	TAG	DEFECT.)	DATE			
	wheelchair and the laptop cushion						
	restraint had been applied due to the resident had tried to put her feet over the						
	side of the comfort chair and climb out of						
	the chair. LPN #6 indicated when the						
	resident had become restless the staff						
	intervened with 1:1 activities and a snack						
	was tried prior to applying the laptop						
	cushion to the resident's wheelchair.						
	LPN #6 indicated the resident is not						
	always easily redirected and the staff on						
	the unit had released from the laptop						
	cushion every 2 hours.						
	cusinon every 2 nours.						
	On 4/25/12 at 3:00 p.m. QMA #8 was						
	interviewed in regard to the resident's						
	laptop cushion restraint and indicated the						
	laptop cushion restraint should be						
	released when the resident is in a						
	supervised activity.						
	*						
	On 4/26/12 at 1:15 p.m. Activity Aide #5						
	was interviewed in regard to the resident's						
	padded lap top cushion present during						
	activities. The Activity Aide #5 indicated						
	the resident can be so unpredictable in						
	regard to her movements and at times the						
	resident becomes very anxious. The						
	Activity Aide #5 indicated the resident						
	had been more sleepy this week.						
	3.1-26(h)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155512			04/26/2012
			B. WING		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				MAIN ST	
PROVEN	A SACRED HEART	ГНОМЕ	AVILLA	, IN 46710	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROVIDENIS DI AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F0225	483.13(c)(1)(ii)-(i	······································			
SS=D	INVESTIGATE/F				
00-D	ALLEGATIONS/				
		not employ individuals who			
		I guilty of abusing,			
		streating residents by a court			
		ad a finding entered into the			
		registry concerning abuse,			
		ment of residents or			
		of their property; and report			
	any knowledge it	t has of actions by a court of			
	law against an e	mployee, which would			
	indicate unfitness	s for service as a nurse aide			
	or other facility s	taff to the State nurse aide			
	registry or licens	ing authorities.			
	_	ensure that all alleged			
		ng mistreatment, neglect, or			
		injuries of unknown source			
		ation of resident property are			
		ately to the administrator of			
	•	o other officials in accordance			
		rough established			
		uding to the State survey and			
	certification ager	icy).			
	The f09 (have evidence that all			
		have evidence that all			
	_	s are thoroughly investigated,			
		It further potential abuse gation is in progress.			
	wille the investig	gation is in progress.			
	The results of all	investigations must be			
		dministrator or his			
	•	esentative and to other			
		dance with State law			
		State survey and certification			
		working days of the incident,			
	• • • •	d violation is verified			
		ective action must be taken.			
		review and interview,	F0225	All abuse, neglect or	05/18/2012
			- 0	mistreatment allegations will be	
	the facility failed	to ensure 1 of 8 possible		throughly investigated and	-

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI 111	. BUILDING		COMPLETED	
		155512	B. WIN			04/26/2	012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t .			MAIN ST		
PROVEN	IA SACRED HEAR	ГНОМЕ		AVILLA	, IN 46710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE '	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	abuse, neglect, o				reported promptly to Administrator and officials in		
	_	thoroughly investigated			accordance with state law. Th	ie	
		mptly to other officials in			abuse policy was updated on		
	accordance with	State law.			4-25-2012, see attached. The		
	Findings include	:			abuse investigation form will b completed and submitted as required. Staff will be inservice on the abuse policy by		
	During a routine	interview for			5-18-2012. Any unusual		
	_	ocedures RN #1 indicated			occurrences, abuse, neglect o	r	
	an incident which	h occurred approximately			mistreatment allegations and		
		nere resident #34 said he			suspicion of crime will be brou	ght	
		ome guy during the night.			to the QA team monthly for review. The administrator will		
	·····-				review abuse, neglect, or		
	On 4/26/12 at 9:0	00 A.M. the Director of			mistreatment allegations, unus		
		provided a document			occurrences, and suspicion of		
		2:30 A.M. from the			crimes ongoing to ensure prop investigation and reporting	er	
		trator which indicated			procedures are being		
	_	ying that a guy beat him			followed.Administrator		
		PN #9 reported the			responsibleAdministrator will		
		nall bruise left deltoid			monitorQA Team will monitor		
		g. LPN #9 reported the			monthly		
		•					
		ss while being transferred					
	_	with 2 staff assist and he					
		The document indicated					
		N #9 contacted the					
		nd stated the resident's					
	<u> </u>	r lunch and she told them					
		t had been saying about					
	_	PN #9 reported the family					
		nt used to say that all the					
	time at the previo	ous nursing home he was					
	at. The documer	nt continued, "based on					
	resident minor ex	xtremity bruising,					
	resident diagnose	es, staff interview and					

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155512	B. WIN	G		04/26/2	2012
NAME OF E	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			515 N N	IAIN ST		
	IA SACRED HEAR	T HOME		AVILLA,	, IN 46710		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
IAG				TAG	DEFICIENC!)		DATE
	1	this 'alleged' incident					
	did not occur".						
	An interview wit	th the Administrator on					
		A.M. indicated they					
		•					
		CNA's working during					
	_	ent but didn't include the					
		nuse the family said the					
		ed similar things in the					
	•	dent was not reported to					
		Department of Health					
	(ISDH).						
	An interview wit	th the DON on 4/26/12 at					
		cated she felt the incident					
		need to be reported as					
		•					
		ted the information about					
	_	st allegations of being					
		ne night 1/2 hour after the					
		rted. The DON also					
	1	ere initially going to					
	_	0 pending the outcome					
	_	on but CNA #10 was not					
	scheduled to wor	rk the next day anyway.					
	Review of the fa	cility policy "Reporting					
		of neglect and/or					
		n of resident property"					
		dicated under section 1.,					
		se, neglect, administration					
	responsibilities:	_					
	_	signee, on becoming					
		_					
	_	abuse, neglect and/or					
	misappropriation	of a resident's property,					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(A2) M	ULTIPLE CO.	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	OF CORRECTION	155512		LDING	00	04/26/	
		133312	B. WIN			04/20/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PROVEN	IA SACRED HEAR	ГНОМЕ		515 N M AVILLA,	, IN 46710		
(X4) ID	SUMMARY S'	FATEMENT OF DEFICIENCIES		ID	DROWIDERIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i.c.	DATE
	shall report the n	natter immediately by					
	telephone to the	following: a. the					
	resident's represe	entative; b. Regional					
	Office of the Ind	iana Department of					
		tilize the Hot Line on					
	weekends/holida						
		cal Ombudsman; e. Local					
	1 ^ *	nt (if sexual or physical					
		II, investigation of abuse,					
	· · · · · · · · · · · · · · · · · · ·	opriation of property					
		nvestigation will include,					
		ed to: "date, time, place,					
		rrounding the occurrence					
		appropriate parties.					
	'	e conducted as early as					
		ng an alleged incident;					
	names of residen						
		ling statements and					
		ritten statements". Under					
	-	iployee as perpetrator:					
		immediately suspended					
		duty pending the outcome					
	of the investigati						
	of the investigati	on .					
	3.1-28(c)(d)						
	3.1-28(c)(u)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155512	B. WING		04/26/2012	
	PROVIDER OR SUPPLIE		515 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST A, IN 46710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0226 SS=D	ETC POLICIES The facility mus written policies mistreatment, n residents and m property. Based on record facility failed to was implemente abuse, neglect, of allegations were and reported pro accordance with Findings include During a routine abuse/neglect pro an incident which 3 months ago w was beat up by so On 4/26/12 at 9 Nursing (DON) dated 1/9/12 at 1 facility Administ resident #34 "sa up last night". It resident had a si and lower left left resident is restleft via stand up lift	t develop and implement and procedures that prohibit eglect, and abuse of hisappropriation of resident. I review and interview the ensure the Abuse policy ed for 1 of 8 possible or mistreatment ethoroughly investigated omptly to other officials in a State law (Resident #34).	F0226	All abuse, neglect or mistreatment allegations will be thoroughly investigated and reported promptly to the administrator and officials in accordance with state law. The abuse policy was updated on 4-25-2012, see attached. The abuse investigation form will be completed and submitted as required. Staff will be inservice on the updated abuse policy be 5-18-2012. Any unusual occurrences, abuse, neglect of mistreatment allegations and suspicion of crime will be brought to the QA team monthly for review. The administrator will review abuse, neglect, or mistreatment allegations, unus occurrences, and suspicion of crimes ongoing to ensure proprinvestigation and reporting procedures are being followed. Administrator response Administrator will monitor Manual monitor monthly	ne e e e ed y or ght sual per	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155512 NAME OF PROVIDER OR SUPPLIER PROVENA SACRED HEART HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PROVIDER'S PLAN OF CORRECTION (X6) PROVIDER'S PLAN OF CORRECTION (X7) PROVIDER'S PLAN OF CORRECTION (X8) PROVIDER'S PLAN OF CORRECTION (X8) PROVIDER'S PLAN OF CORRECTION (X9) PROVIDER'S PLAN	TION
NAME OF PROVIDER OR SUPPLIER PROVENA SACRED HEART HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710 (X5) PROVIDER'S PLAN OF CORRECTION (X5)	TION
PROVENA SACRED HEART HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES	TION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X:	TION
PROVIDER'S PLAN OF CORRECTION	TION
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG: PEGLII ATORY OR LSC IDENTIFYING INFORMATION: TAG: DEFICIENCY DAT	5 .
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) at 1:00 P.M. LPN #9 contacted the	
Administrator and stated the resident's	
family was in for lunch and she told them	
what the resident had been saying about	ļ
being beat up. LPN #9 reported the family	ļ
stated the resident used to say that all the	
time at the previous nursing home he was	ļ
at. The document continued, "based on	ļ
resident minor extremity bruising,	
resident diagnoses, staff interview and	
family statement, this 'alleged' incident	
did not occur".	
An interview with the Administrator on	
4/26/12 at 10:30 A.M. indicated they	
interviewed the CNA's working during	
the alleged incident but didn't include the	ļ
information because the family said the	
resident had stated similar things in the	
past and the incident was not reported to	
the Indiana State Department of Health	
(ISDH).	
An interview with the DON on 4/26/12 at	
11:00 A.M. indicated she felt the incident	
of 1/9/12 did not need to be reported as	ļ
the family reported the information about	ļ
the resident's past allegations of being	
beat up during the night 1/2 hour after the	ļ
investigation started. The DON also	ļ
indicated they were initially going to	ļ
suspend CNA #10 pending the outcome	ļ
of the investigation but CNA #10 was not	
scheduled to work the next day anyway.	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	(X3) DATE COMPI	
MADILAN	OI COMMECTION	155512		LDING			/2012
		100012	B. WIN		ADDRESS OF VICTOR OF THE CORE	0-1/20	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE MAIN ST		
PROVEN	IA SACRED HEART	ГНОМЕ			, IN 46710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	BEI ICE. CT)		DATE
	Davious of the fo	cility policy "Reporting					
		of neglect and/or					
	_	n of resident property"					
		dicated under section 1.,					
		e, neglect, administration					
	responsibilities: '	_					
	•	signee, on becoming					
		abuse, neglect and/or					
	_	of a resident's property,					
		natter immediately by					
	telephone to the						
	_	entative; b. Regional					
	•	iana Department of					
		tilize the Hot Line on					
	weekends/holida						
		cal Ombudsman; e. Local					
		nt (if sexual or physical					
		II, investigation of abuse,					
	*	opriation of property					
		nvestigation will include,					
		ed to: "date, time, place,					
		rrounding the occurrence					
		appropriate parties.					
		e conducted as early as					
	possible following	ng an alleged incident;					
	names of residen	t, employee(s),					
	witness(s) provid	ling statements and					
		ritten statements". Under					
	section III. B. en	ployee as perpetrator:					
	"the employee is	immediately suspended					
	(with pay) from (duty pending the outcome					
	of the investigati	on".					
	-						

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	OF CORRECTION	IDENTIFICATION NUMBER: 155512	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI 04/2	PLETED 6/2012
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZII MAIN ST	P CODE	-
PROVEN	IA SACRED HEAR	ТНОМЕ		, IN 46710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	3.1-28(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155512			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/26/2012	
	PROVIDER OR SUPPLIER		S. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE MAIN ST ,, IN 46710		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0252 SS=E	ENVIRONMENT The facility must comfortable and allowing the resid personal belongi Based on observa the facility failed Resident bathroo were properly ma attached firmly to wall-storage-com affected 3 of 3 in and #23) resident sampled Residen Findings include On 4/25/12 from p.m. an environm conducted along Director. On observation v environmental to bathroom located rooms. A bed par the Resident's ba Resident bathroo approximately fo include a one sea pan sprayer is a h device designed in	provide a safe, clean, homelike environment, dent to use his or her ings to the extent possible. Actions and interviews, at to ensure the private instance and were to the inecters. This potentially a sample of 3 (#51, #62 its who utilized the its private bathroom's. 10:10 a.m. until 12:45 inental tour was with the Maintenance was made during the interviews and interviews in sprayer was observed in throoms. The private	F02	52	The bed pan sprayers were all removed from the private and semi-privatre residents bathrooms. All fixtures will be cleaned and capped by 5-15-2012. Maintenence will complete an environmental checklist weekly on all neighborhoods to ensure and monitor proper maintenance throughout the facility.Property Manager responsible Property Manager to monitor	/	05/15/2012

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	OF CORRECTION	IDENTIFICATION NUMBER: 155512	A. BUII	DING	00	COMPLETED 04/26/2012	
		100012	B. WIN	_		04/20/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PROVEN	IA SACRED HEART	HOME		515 N M AVILLA,	, IN 46710		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ted above seated head					
		handed side of the wall.					
	The hand held sp						
		ed operation and was					
	heavier in weight						
		eup of the hand held					
		ated by the pressing of an					
		th hand grasp allowing					
	•	urized water to be					
	released. The me	chanics also include a					
	storage handle lo	cated approximately four					
	feet from the floo	or. This storage handle					
	was used to percl	h the hand held sprayer					
	onto between use	es. The storage of the					
	hand held spraye	r balances upon the					
	perch.						
	On 4/25/12 at 11	:05 a.m. an observation					
	was made of a be	ed pan sprayer in room					
	#13 of the Saint ((St.) Claire unit. The					
	hand held spraye	r was missing the					
	attached lever for	r activating the pressure					
	release for water	use. A lever and two					
	screws were lying	g on the toilet tank lid.					
	On 4/25/12 at 11	:06 a.m. an interview					
	with the Mainten	ance Director indicated					
	the lever belonge	ed to the bed pan sprayer					
	and looked "brok						
	On 4/25/12 at 11	:07 a.m. an interview					
	with the Mainten	ance Manager for St.					
	Claire unit indica	ated a work order for					
	repair had not be	en completed.					
			<u> </u>				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
		155512	A. BUI B. WIN	LDING G		04/26/	2012
NAME OF L	DROVADED OD GUDDI IED		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	1	
	PROVIDER OR SUPPLIER			515 N M			
PROVEN	NA SACRED HEAR	ГНОМЕ		AVILLA,	, IN 46710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	-	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
TAG	On 4/25/12 at 11 was made of the the St Claire prival An observation of directly underness the bed pan spray have numerous of in the linoleum to the linoleum	:08 a.m. an interview nance Manager for St. neted. When questioned ion of the gashes, it was Maintenance Manager from the hand held ff of the handle designed sprayer for storage. End about the uses of the ers the Maintenance Claire indicated the of the bed pan sprayers to d. :08 a.m. an interview nance Director was fling the potential hazard bed pan sprayer falling handle and physically at. The Maintenance end it was a possibility. "		TAG	DEFICIENCY)	nie.	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155512	B. WING		04/26/2012
	PROVIDER OR SUPPLIE		515 N I	ADDRESS, CITY, STATE, ZIP CODE MAIN ST A, IN 46710	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) ilt in "1977" and the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		e bed pan sprayers were cannot be ordered any			
	of room #17 of the was conducted. bed pan sprayer private bathroom "cipher brake" to lever for pressin pressurized water sprayer. The M the dripping water packing needs to the dripping was conducted. The Residents probserved. The language of the Mainter confirmed that the backwards" On 4/25/12 at 11 was made for room #4 of the Sprivate Residents"	er was missing from the aintenance Director noted ter and indicated the " of be tightened as well" 1:30 a.m. an observation whe Saint (St.) Paul unit. The bed pan sprayer of ivate bathroom was ever to the sprayer was ward. Upon interview mance Director is was the lever handle was on " 1:35 a.m. an observation om #4. The Resident of St Paul unit was using the stathroom and the exame room was awaiting			
	w use the Kesig	ont daundom.			

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PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI	AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER: 155512	A. BUILDING B. WING	00	COMP 04/26	E SURVEY PLETED 6/2012
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI				515 N I	MAIN ST	P CODE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DA	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
On 4/25/12 at 12:15 p.m. an interview with the Maintenance Manager of the St. Claire unit was made indicating, " maintenance rounds are made every Monday and the bed pan sprayers were all working fine then" On 4/25/12 at 4:15 p.m. an interview with the Administrator, DNS and Assistant Administrator was conducted. It was indicated that the bed pan sprayers were not a potential hazard for the Residents due to the factor that the private Resident bathrooms were not being used for private Resident usage. On 4/26/12 at approximately 11:00 a.m. an interview was conducted with the Administrator, the Assistant Administrator, the Assistant Administrator, the Sasistant Administrator was conducted with the Administrator, the St. Claire unit was actively using only one private Resident bathroom; the St. Francis unit did not use the private Resident bathrooms at all; the St. Paul and the St Anthony units used the private Resident bathrooms "most of the time"		On 4/25/12 at 12 with the Mainten Maintenance Ma unit was made in maintenance rou Monday and the all working fine On 4/25/12 at 4: the Administrator windicated that the not a potential he due to the factor bathrooms were Resident usage. On 4/26/12 at again interview was Administrator, the Administrator at indicated that the actively using on bathroom; the Stephen St. Paul and the private Resident time"	2:15 p.m. an interview nance Director and anager of the St. Claire ndicating, " ands are made every ne bed pan sprayers were then " 15 p.m. an interview with or, DNS and Assistant as conducted. It was the bed pan sprayers were azard for the Residents that the private Resident not being used for private as conducted with the he Assistant the DNS. It was the St. Claire unit was ally one private Resident to the Private Resident to the DNS. It was the St. Claire unit was ally one private Resident to the Private Resident to the DNS and the St. Claire unit was ally one private Resident to the St. Anthony units used the				

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	OF GODDECTION	X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155512	B. WIN	G		04/26/	2012
NAME OF E	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	-	
TWINE OF I	ROVIDER OR SOLITEIER				MAIN ST		
PROVEN	IA SACRED HEART	HOME		AVILLA	A, IN 46710		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323 SS=E	483.25(h) FREE OF ACCID HAZARDS/SUPE The facility must environment rem hazards as is por receives adequar assistance device Based on observation facility failed to or Resident bathroor were properly matached firmly to wall-storage-com affected 3 of 3 (# Residents whom Resident's private On 4/25/12 from p.m. an environm conducted along Director. On observation went of the Resident's bathroom located rooms. A bed pan the Resident's bathroor approximately for include a one seat pan sprayer is a head of the resident of the	DENT ERVISION/DEVICES ensure that the resident lains as free of accident sible; and each resident te supervision and es to prevent accidents. ations and interviews the ensure the private ms' bed pan sprayers aintained and were to the necters. This potentially est, #62 and #23) of the utilized the sampled te bathroom's. 10:10 a.m. until 12:45 nental tour was with the Maintenance was made during the ur of the each private d with in the Residents' in sprayer was observed in throoms. The private	F03	23	The bed pan sprayers were removed from private and semi-private resident bathroor All fixtures will be cleaned and capped by 5-15-2012. Maintenance will complete an environmental checklist on all neighborhoods weekly to ensure and monitor proper maintenance throughout the facility.Property Manager responsible Property Manager will monitor	I	05/15/2012

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155512	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/26	
	PROVIDER OR SUPPLIER		STREET A	.DDRESS, CITY, STATE, ZIP CODE 1AIN ST , IN 46710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	hose. It was local height on the left The hand held spresembled an age heavier in weigh mechanical maked device was activated attached lever with the flow of press released. The mestorage handle lofeet from the flow was used to perconto between use hand held sprayed perch. On 4/25/12 at 11 was made of a be #13 of the Saint hand held sprayed attached lever for release for water screws were lyin. On 4/25/12 at 11 with the Maintenthe lever belonged and looked "broken."	rater source through a sted above seated head shanded side of the wall. The properties of the hand held at the hand grasp allowing surized water to be exchanics also include a seated approximately four for. This storage handle shand held sprayer es. The storage of the extra balances upon the extra balances upon the extra balance and two gon the toilet tank lid. 1:06 a.m. an interview stance Director indicated extra to the bed pan sprayer exercises."				

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	OF CORRECTION	IDENTIFICATION NUMBER: 155512	A. BUII	LDING	00	COMPLETED 04/26/2012	
		100012	B. WIN			04/20/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PROVEN	IA SACRED HEART	HOME			/AIN ST , IN 46710		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Έ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	repair had not be	en completed.					
	On 4/25/12 at 11	:08 a.m. an observation					
		flooring in room #13 of					
	-	rate Resident bathroom.					
		vas made of the floor					
	· ·	ath the storage handle for					
		yer. It was observed to					
		oncave indented gashes					
	in the linoleum ty	ype flooring.					
	On 4/25/12 at 11	:08 a.m. an interview					
	with the Mainten	ance Manager for St.					
		icted. When questioned					
		ion of the gashes, it was					
		Maintenance Manager					
		from the hand held					
		ff of the handle designed					
		sprayer for storage.					
		ed about the uses of the					
		rs the Maintenance					
		laire indicated the					
	_	of the bed pan sprayers to					
	be currently used						
	asout the same of						
	On 4/25/12 at 11	:08 a.m. an interview					
	with the Mainten	ance Director was					
	conducted about	the potential hazard of					
	the hand held bed	d pan sprayer falling					
		handle and physically					
		t and it was confirmed of					
	_	Yes, I see what you					
		ibility" It was also					
	_	e that this particular					
	stated at that time	e that this particular					

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-	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		155512	B. WIN	G		04/26/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PROVEN	IA SACRED HEART	НОМЕ		515 N M AVILLA,	IAIN ST , IN 46710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
		ilding was built in		0			51112
	1 ^	nechanics of the bed pan					
		old and parts cannot be					
		-					
	of room #17 of the was conducted. It bed pan sprayer I private bathroom "cipher brake" to lever for pressing pressurized water sprayer. The Mathe dripping water packing needs to On 4/25/12 at 11 of room #11 of the was conducted. It he Residents privates a with the Mainten confirmed that the backwards" On 4/25/12 at 11 was made for room #4 of the Steprivate Resident	2.15 a.m. an observation he Saint (St.) Francis unit at was observed that the ocated in the Resident's to be broken and the be dripping water. The sto activate the read was missing from the intenance Director noted er and indicated the " be tightened as well" 2.30 a.m. an observation he Saint (St.) Paul unit The bed pan sprayer of wate bathroom was ever to the sprayer was ward. Upon interview ance Director is was he lever handle was on " 2.35 a.m. an observation of the Paul unit was using the bathroom and the same room was awaiting					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		155512	A. BUI B. WIN	LDING		04/26/	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			515 N M	MAIN ST		
PROVEN	IA SACRED HEAR	ГНОМЕ		AVILLA,	, IN 46710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		:15 p.m. an interview		1710	·		DATE
		nance Director and					
		nager of the St. Claire					
	unit was made in	•					
	maintenance rou	nds are made every					
	Monday and th	e bed pan sprayers were					
	all working fine	then"					
	0.4/05/10.44	1.5					
		15 p.m. an interview with					
		or, DNS and Assistant as conducted. It was					
		e bed pan sprayers were					
		azard for the Residents					
	-	that the private Resident					
		not being used for private					
	Resident usage.						
		proximately 11:00 a.m.					
		conducted with the					
	Administrator, th						
		nd the DNS. It was					
		e St. Claire unit was					
		aly one private Resident					
		. Francis unit did not use lent bathrooms at all; the					
	•	St Anthony units used the					
		bathrooms "most of the					
	time"	iiost of the					
	3.1-45(a)(1)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE S	ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DDIC	00	COMPLETED		
		155512	A. BUIL B. WING			04/26/	2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				MAIN ST			
DDOVEN	A SACRED HEART	T HOME			, IN 46710			
INOVLIN	A SACILLY HEART	THOME		AVILLA	, 111 407 10			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0329 SS=D	UNNECESSARY Each resident's of from unnecessar drug is any drug dose (including of excessive duratic monitoring; or wi for its use; or in to consequences we should be reduce combinations of Based on a complexident, the faci residents who had drugs are not give antipsychotic dru treat a specific of documented in the residents who us receive gradual of	N IS FREE FROM O' DRUGS drug regimen must be free ry drugs. An unnecessary when used in excessive duplicate therapy); or for on; or without adequate thout adequate indications the presence of adverse which indicate the dose ed or discontinued; or any the reasons above. prehensive assessment of a dity must ensure that ave not used antipsychotic wen these drugs unless ag therapy is necessary to ondition as diagnosed and the clinical record; and se antipsychotic drugs dose reductions, and tentions, unless clinically						
	these drugs. Based on record	in an effort to discontinue review and interview the	F032	29	Resident #34 was re-evaluated		05/18/2012	
	facility failed to				confirm that no negative outco occurred as a result of the alle			
		of 9 residents (#34)			deficiency. All other residents	-		
	receiving psycho sample of 24.	tropic medications in a			who receive psychotropic medications have the potential be affected by the alleged			
	Findings include	:			deficiency. Inservice training was be provided to staff by 5/18/12 ensure that any psychotropic of	to		
	reviewed on 4/24 record indicated to the facility on	inical record was 4/12 at 9:00 A.M The the resident was admitted 11/14/11 and had ing, but not limited to,			other medications used for behaviors will have a behavior intervention monthly flow recor see attached, included in the MAR. Pharmacy will provide a of medications that require a	⁻ d,		

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NAME OF PROVIDER OR SUPPLIER PROVENA SACRED HEART HOME (X4) ID SUMMARY STATIMENT OF DETICIENCIES (EACH DERICENCY MIST BE PERCEDED BY FULL TAG REGULATORY OR IS LEDENTHYM IN STOROMATION) Alzheimer's dementia with agitation and sexually inappropriate behavior due to dementia. The resident's current physician's orders from 3/25/12 indicated the resident was receiving medications including, but not limited to, Depo-Provera 200 mg by intramuscular injection every 2 months. Review of departmental notes from 12/7/11 indicated Depo-Provera was originally ordered for socially inappropriate behaviors. Review of resident #34's health care plans indicated on 11/23/11 a care plan was initiated for problem/need: "can be socially inappropriate during care towards staff' by touching himself and talking in a sexual manner," Approaches included: speak to resident in a calm and direct manner, provide redirection when resident is speaking in a sexual manner; monitor resident's mood and behavior and notify MD of any significant changes; encourage resident to reminisce about the past, introduce him to like peers; if resident is being inappropriate during care then ask for another staff member for help; remind resident his behavior is inappropriate; distract resident when having inappropriate behaviors, talk about his children or working with heavy machinery; keep daily routine as consistent as possible. On 12/7/12 the		OF CORRECTION	IDENTIFICATION NUMBER: 155512	A. BUII	LDING	00	COMPLETED 04/26/2012	
PROVENA SACRED HEART HOME (NA) ID SUMMARY STATISHENT OF DETICINCES (LACIT DETICUTY MISS IN PURCUIDATION) Alzheimer's dementia with agitation and sexually inappropriate behavior due to dementia. The resident's current physician's orders from 3/25/12 indicated the resident was receiving medications including, but not limited to, Depo-Provera 200 mg by intramuscular injection every 2 months. Review of departmental notes from 12/7/11 indicated Depo-Provera was originally ordered for socially inappropriate behaviors. Review of resident #34's health care plans indicated on 11/23/11 a care plan was initiated for problem/need: "can be socially inappropriate during care towards staff by touching himself and talking in a sexual manner," Approaches included: speak to resident in a calm and direct manner, provide redirection when resident is speaking in a sexual manner, monitor resident is mod and behavior and notify MD of any significant changes; encourage resident to reminisce about the past, introduce him to like peres; if resident is being inappropriate during care then ask for another staff member for help; remind resident his behavior is inappropriate, distract resident when having inappropriate behaviors, talk about his children or working with heavy machinery; keep daily routine as			100012	B. WIN			04/20/	2012
PROVENA SACRED HEART HOME AVILLA, IN 46710 SUMMARY STATEMENT OF DEFICIENCES TO SUMMARY STATEMENT OF DEFICIENCE OF THE PROPERTY OF THE APPROPRIATE	NAME OF P	ROVIDER OR SUPPLIER						
RECULATORY OR LOCK IDENTIFYING INFORMATION) Alzheimer's dementia with agitation and sexually inappropriate behavior due to dementia. The resident's current physician's orders from 3/25/12 indicated the resident was receiving medications including, but not limited to, Depo-Provera 200 mg by intramuscular injection every 2 months. Review of departmental notes from 12/7/11 indicated Depo-Provera was originally ordered for socially inappropriate behaviors. Review of resident #34's health care plans indicated on 11/23/11 a care plan was initiated for problem/need: "can be socially inappropriate during care towards staff' by touching himself and talking in a sexual manner," Approaches included: speak to resident in a calm and direct manner, provide redirection when resident to reminisce about the past, introduce him to like peers; if resident is being inappropriate during care then ask for another staff member for help; remind resident his behavior is inappropriate; distract resident when having inappropriate behaviors, talk about his children or working with heavy machinery; keep daily routine as	PROVEN	IA SACRED HEART	HOME					
dementia. The resident's current physician's orders from 3/25/12 indicated the resident was receiving medications including, but not limited to, Depo-Provera 200 mg by intramuscular injection every 2 months. Review of departmental notes from 12/7/11 indicated Depo-Provera was originally ordered for socially inappropriate behaviors. Review of resident #34's health care plans indicated on 11/23/11 a care plan was initiated for problem/need: "can be socially inappropriate during care towards staff by touching himself and talking in a sexual manner". Approaches included: speak to resident in a calm and direct manner; provide redirection when resident is speaking in a sexual manner, monitor resident's mood and behavior and notify MD of any significant changes; encourage resident to reminisce about the past, introduce him to like peers; if resident is being inappropriate during care then ask for another staff member for help; remind resident his behavior is inappropriate, distract resident when having inappropriate behaviors, talk about his children or working with heavy machinery; keep daily routine as	PREFIX	(EACH DEFICIENC REGULATORY OR	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) behavior intervention monthly	flow	COMPLETION
having inappropriate behaviors, talk about his children or working with heavy machinery; keep daily routine as	TAG	Alzheimer's demosexually inappropried dementia. The resphysician's orders the resident was a including, but not Depo-Provera 20 injection every 2 departmental note indicated Depo-Provera departmental note indicated Depo-Provera departmental note indicated for social behaviors. Review of resident indicated on 11/2 initiated for probles ocially inappropried sexual manner', speak to resident manner; provide resident is speaking monitor resident's notify MD of any encourage resident past, introduce his resident is being then ask for anoth help; remind resident reside	entia with agitation and priate behavior due to sident's current is from 3/25/12 indicated receiving medications it limited to, 0 mg by intramuscular months. Review of less from 12/7/11 provera was originally lly inappropriate Int #34's health care plans lem/need: "can be briate during care towards himself and talking in a Approaches included: in a calm and direct redirection when ling in a sexual manner; is mood and behavior and or significant changes; int to reminisce about the like peers; if inappropriate during care ther staff member for dent his behavior is		TAG	behavior intervention monthly record. The medication list wil added to the front of each MAF throughout the facility for reference. Unit nurse will ensu that all behavior intervention monthly flow records are present the MAR monthly. Unit nurse responsible DON to monitor QAF	Ibe R re ent is	DATE
Total and possible on 12/1/12 and		having inappropr his children or we machinery; keep	iate behaviors, talk about orking with heavy daily routine as					

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-	OF CORRECTION	IDENTIFICATION NUMBER: 155512	A. BUII B. WIN	LDING	00	COMPLETED 04/26/2012	
	ROVIDER OR SUPPLIER		D. WIN	STREET A			
PROVEN (X4) ID	SACRED HEART SUMMARY ST	THOME TATEMENT OF DEFICIENCIES		ID ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	health care plan vuse of Depo Prov	was updated to include vera.					
	Review of the resintervention monincluded behavior anxiousness, negawhen family leave behavior intervention include in behavior and outdintervention moninclude socially in the control of	sident's behavior thly flow records rs of restlessness, ative statements, upset res and agitation. The ation monthly flow atterventions for each comes. The behavior thly flow records did not appropriate behaviors. The Social Service and 4/25/12 at 10:00 A.M. se's do the behavior thly flow records. The adid not know why avior intervention ord for socially and behaviors for The unit manager, RN and the unit manager, R					
		ted 2/17/2000 indicated					

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	DF CORRECTION IDENTIFICATION NUMBER: 155512		00 	COMPLETED 04/26/2012
	ROVIDER OR SUPPLIER A SACRED HEART HOME	515 N N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST ,, IN 46710	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PERCEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	under procedure II: "observed behavior and suggested interventions for the behavior exhibited will be documented the resident's care plan by licensed statimmediately after the behavior occurs' 3.1-48(a)(3)	r d in ff		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155512	B. WING		04/26/2012
	ROVIDER OR SUPPLIER		515 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST A, IN 46710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	SSIBLE The facility must each resident in professional star complete; accura accessible; and some complete; accura accessible; and some complete; accura accessible; and some care and service preadmission some state; and progressate; and progressate on observation interviews, the fainitial nursing as documented regar pressure ulcer for reviewed for preson of 24. (Resident Finding includes 1. During the information of the indicate on 04. A.M 11:30 A.M. Manager, indicate unstageable prescheel. She indicate with a blister on acute care center of a fractured left.	ation, record review, and acility failed to ensure an assessment was accurately arding the presence of a r 1 of 6 residents assure ulcers in a sample #103) tial tour of the facility, 723/12 between 11:00 M., R.N. #2, the Unit ed Resident #103 had an assure ulcer on his right ted he had been admitted this right heel from an following surgical repair	F0514	Resident #103 was re-evaluate to confirm that no negative outcome occurred as a resulte the alleged deficiency. All otheresidents have the potential to affected by the alleged deficiency. Inservice training provided to RN #4 on how to properly complete an admission assessment on 4-25-2012, se attached. Nursing staff will util the admission check off list for new admissions/readmissions see attached. Admission nursus assessment will be completed within 24 hours of admission. Admission checkoff list will be audited on new admissions with 48 hours. Inservice training with the provided to staff by 5/18/12. Nurse responsible DOmonitorQA Team to monitor monthly	of er b be was on e illize r all s, sing

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-	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00 	COMPLETED 04/26/2012	
		155512	B. WIN	G		04/26/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PROVEN	IA SACRED HEART	HOME			1AIN ST , IN 46710		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	ŕ	ated in his wheelchair in					
	_	lounge on the rehab unit.					
		noted to have a quilted					
		nt foot and a dressing was					
	visible on the hee	el area.					
	_	oressure ulcer was					
		4/12 at 2:45 P.M. The					
		unded, silver dollar sized					
	*	the bottom posterior					
	_	neel. The bottom portion					
		s a dried, brown colored					
		d area the top 1/3 and a					
	•	e blister was noted to be					
		ck, thick tissue. RN #2					
	indicated she wor	uld call the black area,					
	eschar. The esch	ar area covered the entire					
	top 1/3 of the orig	ginal blistered area, was					
	shaped like a but	ton mushroom cap, and					
	was thick and vis	sibly rimmed on one side					
	of the eschar area	a. The top of the					
	resident's foot and	d toes were pink in color.					
	The clinical recor	rd for Resident #103 was					
	reviewed on 04/2	23/12 at 2:30 P.M.					
	Resident #103 wa	as admitted to the facility					
	on 04/06/12 from	an acute care facility					
	with diagnoses, in	ncluding but not limited					
	to, status post lef	t hip fracture repair,					
	atrial fibrillation,	history of a cerebral					
	vascular accident	t, hypertension, and					
	constipation.						
	Review of an elec	ctronic Admission					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155512		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			COMPI	(X3) DATE SURVEY COMPLETED 04/26/2012		
NAME OF PROVIDER OR SUPPLIER PROVENA SACRED HEART HOME			B. WING O472072012 STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710					
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	2:46 A.M., by Rl section i. "Integrate skin was noted and incision were there was a place	apleted on 04/07/12 at N #4, indicated under umentary" the resident's spale in color, a bruise edocumented. Although to document a blister, essure ulcer, none were						
	notes, completed at 11:48 P.M., an 4:09 P.M., indica documented an a resident's system	ssessment of all of the s and body, but failed to er or impaired skin on the						
	by RN #4, dated presence of a her	n flowsheet", completed 04/06/12 indicated the natoma "ota" (open to ed with sheepskin.						
	orders, dated 04/ were no specific and/or treatment resident's right he documentation fi	om the acute care center a pressure ulcer or blister						
		ess note, dated 04/07/12 dicated the following:						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION				. BUILDING 00			COMPLETED 04/26/2012	
		155512	B. WIN	_		04/26/2	2012	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
			515 N MAIN ST AVILLA, IN 46710					
PROVENA SACRED HEART HOME					, 111 407 10			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) "On res (resident's) right heel there is a			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG				PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
1710				1710			Ditte	
	hematoma that measures 4.5 x 5.4 x<.1. (centimeters) Heel was placed in sheep skin protector" There was no documentation the physician was notified of the resident's pressure ulcer.							
	Pavious of a treatment record for April							
	Review of a treatment record for April 2012 for Resident #103 indicated a							
	pressure relievin							
	^							
	implemented on 04/06/12, and "Monitor hematoma to rt heel et (and) elevate with sheep skin on when in bed" was							
	implemented on							
	•	mes was implemented on						
	•	•						
	04/10/12, and keep right lower extremity elevated in bed/wheelchair was implemented on 04/10/12.							
	implemented on	04/10/12.						
	There was no documentation the							
		otified of the blister on						
		ht heel until an order for						
	_	ent was received on						
	04/13/12.	cht was received on						
	04/15/12.							
	Interview with the	ne Director of Nursing, on						
		A.M., indicated Resident						
		dmitted to the facility on						
		e blister to the right heel.						
		ained from the acute care						
		d the resident had a						
	1	04/04/12. In addition, a						
	note signed by the physician indicated he							
visited the resident at the facility on								
	Island the reside		1					

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	of Correction identification number: 155512	(X2) MULTIPLE COI A. BUILDING B. WING	— COMP. 04/26	COMPLETED 04/26/2012			
NAME OF PROVIDER OR SUPPLIER PROVENA SACRED HEART HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	04/08/12 and was aware of the resident's right heel blister.						
	The Director of Nursing, on 04/25/12 at 9:00 A.M. indicated the Admission Assessment, completed by RN #4 on 04/07/12 was inaccurately documented and she did not know why RN #3 and #4 did not mention the presence of a pressure ulcer in the progress notes until 04/07/12 at 10:55 P.M. 3.1-50(a)(1)						

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